MONTH-END AGENCY REIMBURSEMENT INVOICE FOR CARE/HIPP ENROLLMENT SERVICES PART I

To: Department of Health Services
Office of AIDS
ATTN: CARE/HIPP
P.O. Box 942732
Sacramento, CA 94234-7320

From: Organization name: _____

Mailing address: _____

_____

_____

Expense period: _____ Federal Tax ID Number: _____

Original enrollments	_____	(@ $25.00 each)	$ _____
Recertifications	_____	(@ $25.00 each)	$ _____
HIPP transitions (by the 12th month)	_____	(@ $100.00 each)	$ _____
HIPP transitions (after the 12th month)	_____	(@ $75.00 each)	$ _____
		Total this invoice:	$ _____

I hereby certify that the amount claimed is accurate and a true representation of the amount owed. I have attached the **required** client documentation for each claim. **I understand that failure to provide the required documentation for each claim will result in nonreimbursement.**

_____ _____ _____
Authorized signature (fiscal representative) Title Date

Ryan White CARE Act of 1990, Section 2618(c)(4) allows the Department of Health Services, Office of AIDS, to authorize the above administrative payment(s), in the amount shown, for the specified period, and to the presentative payee as indicated.

_____ _____
Authorized signature Date

Fiscal Year		PCA						Index				Object Code			Agency Code		Project Number						Work Phase	

MONTH-END AGENCY REIMBURSEMENT INVOICE
RYAN WHITE CARE ACT HEALTH INSURANCE CONTINUATION PREMIUM PAYMENT REFERRAL
PART II

*Client Last Name, First Initial	Enrollment Date	Recertification Date	HIPP Transition Date
TOTALS			

*__Do not__ enter the full name of the client.